

EXHIBIT B

Nascentia Health Options

Member Handbook



Nascentia
HealthOPTIONS
TOMORROW'S HEALTHCARE TODAY

1050 West Genesee St, Syracuse, NY 13204
(315) 477-4663 | nascentiahealthoptions.org

WELCOME TO NASCENTIA HEALTH OPTIONS MANAGED LONG TERM CARE PLAN

Welcome to Nascentia Health Options Managed Long Term Care (MLTC) plan. The MLTC plan is especially designed for people who have Medicaid and who need health and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits Nascentia Health Options covers since you are enrolled in the plan. It also tells you how to request a service, file a complaint, or disenroll from Nascentia Health Options. Please keep this handbook as a reference, it includes important information regarding Nascentia Health Options and the advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

HELP FROM MEMBER SERVICES

You can call us at anytime, 24 hours a day seven days a week, at the Member Services number below.

There is someone to help you at Member Services:

Monday through Friday

8:00 am - 4:30 pm

Call 888-477-HOME (4663) TTY: 711

After regular business hours, you can reach on-call assistance at 888-477-HOME (4663)

If you do not speak English, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. Also, we have services like:

TTY 711

Information in Large Print

Names and Addresses of Providers Who Specialize in Your Disability

ELIGIBILITY FOR ENROLLMENT IN THE MLTC PLAN

The MLTC plan is for people who have Medicaid. You are eligible to join the MLTC plan if you:

- 1) Are age **18** and older,
- 2) Reside in one of our approved Counties

- 3) Have Medicaid,
- 4) Have Medicaid only or are aged 18-20 with both Medicaid and Medicare **and** are eligible for nursing home level of care
- 5) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, **and**
- 6) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the date of enrollment:
 - a. Nursing services in the home
 - b. Therapies in the home
 - c. Home health aide services
 - d. Personal care services in the home
 - e. Adult day health care,
 - f. Private duty nursing; or
 - g. Consumer Directed Personal Assistance Services

The coverage explained in this Handbook becomes effective on the date of your enrollment in Nascentia Health Options MLTC plan. Enrollment in the MLTC plan is voluntary.

NEW YORK INDEPENDENT ASSESSOR - INITIAL ASSESSMENT PROCESS

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process. NYIA will start the expedited initial assessments at a later date. The initial assessment process includes completing the:

- ***Community Health Assessment (CHA)***: The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care plan.
- ***Clinical appointment and Practitioner Order (PO)***: The PO documents your clinical appointment and indicates that you:
 - have a need for help with daily activities, **and**
 - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIA will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later.

Nascentia Health Options will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care, and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs

with you. The IRP will make a recommendation to Nascentia Health Options about whether the plan of care meets your needs.

Once NYIA completes the initial assessment steps and determines that you are eligible for Medicaid Managed Long Term Care, you then choose which Managed Long Term Care plan to enroll with.

Upon membership to Nascentia Health Options, your assigned Care Manager will visit you to assess your health care needs. The Care Manager in collaboration with you, your caregivers and the interdisciplinary team will develop a person-centered service plan that will address and meet your needs. Our goal is to keep you as healthy and independent as possible out in the community.

We will collaborate with your physician on your plan of care to ensure that you have the services you need to remain safely at home. Your physician will be asked to provide signed orders for your services.

Your Care Manager will authorize services covered by Nascentia Health Options. They will also coordinate those services that are not covered by Nascentia Health Options and paid for by any other insurance you may have.

Your Care Manager and Member Service Representatives are very valuable resources for you and your caregivers. Contact them at 888-4777-HOME (4663) for any questions or information.

If you choose to not enroll in Nascentia Health Options, you should request to withdraw your application with a reason of "not interested". The Health Plan will document in their electronic health record and send you a letter to confirm your request. Your referral to enroll into Nascentia Health Options will then be closed.

If you do not meet eligibility to enroll in Nascentia Health Options as determined by the Nascentia Health Registered Nurse's clinical assessment and review of your records by Nascentia Health's Medical Director, you will be notified of the denial verbally and a letter will be sent to you confirming the denial decision. The Denial of Enrollment will be documented in the health plan electronic medical record and submitted to New York Medicaid Choice.

Plan Member (ID) Card

You will receive your Nascentia Health Options identification (ID) card within 14 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your ID card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at 888-477-HOME (4663)

SERVICES COVERED BY THE NASCENTIA HEALTH OPTIONS MLTC Plan

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services. When you join Nascentia Health Options you will be assigned to a Care Manager. This person will assist in arranging and coordinating care within and outside of our provider network. We will collaborate with your physician on your plan of care to ensure that you have the services you need to remain safely at home. **Your physician will be asked to provide signed orders for your services.** With Nascentia Health Options if you need home care, home delivered meals, or see a dentist your Care Manager will help you arrange it.

Nascentia Health Options is available to you every day and night. If you need to speak to someone after hours or weekends, contact our on-call staff at 888-477-HOME (4663) to assist you.

Additional Covered Services

Because you have Medicaid and qualify for MLTC, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in Nascentia Health Options network. If you cannot find a provider in our plan and there are no additional providers available in Nascentia Health Options network, Nascentia Health Options will work with providers outside of our network for you to get medically necessary services that are covered.

Should your provider decide to leave Nascentia Health Options network and you are in an ongoing course of treatment, you may continue with that provider as we transition you to another within our network. Your care with that provider will continue for up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

- **Outpatient Rehabilitation**
- **Personal Care** (such as assistance with bathing, eating, dressing, toileting and walking)
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies
- **Nutrition**
- **Medical Social Services**
- **Home Delivered Meals and/or meals in a group setting such as a day care**
- **Social Day Care**
- **Non-Emergency Transportation**
- **Private Duty Nursing**

- **Dental**
- **Social/Environmental Supports** (such as chore services, home modifications or respite)
- **Personal Emergency Response System**
- **Adult Day Health Care**
- **Nursing Home Care not covered by Medicare (*provided you are eligible for institutional Medicaid*)**
- **Audiology**
- **DME**
- **Medical Supplies**
- **Prosthetics and Orthotics**
- **Optometry**
- **Consumer Directed Personal Assistance Services**
- **Podiatry**
- **Respiratory Therapy**

Person Centered Service Planning and Care Management

Upon enrollment, you will be assigned a Care Manager who will assist you to access necessary covered services as identified in your person-centered service plan. (PCSP) It also provides referral and coordination of other services in support of your PCSP Care management services will assist you to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP even if the needed services are not covered under Nascentia Health Options.

Home Care Services (Nursing, Therapy, Home Health Aide and Personal Care)

Home care is one of the key components to maintaining you in your home and community. Your Care Manager will assess your home care needs and determine the frequency that you will require these services. They will authorize the amount of service that is determined to meet your medical and personal care needs. Home care includes the following services which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.

Nursing Services

Include intermittent, part-time and continuous nursing services provided in accordance with an ordering physician's treatment plan as outlined in the physician's recommendation. Nursing services must be provided by RNs and LPNs in accordance with the Nurse Practice Act. Nursing services include care rendered directly to the individual and instructions to his family or caretaker in the procedures necessary for the patient's treatment or maintenance.

Physical Therapy (PT)

Rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Physical therapy services provided in home and

community based settings.

Occupational Therapy (OT)

Rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Occupational Therapy services provided in home and community based settings.

Speech-Language Pathology (SP)

A licensed and registered speech-language pathologist provides rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Speech Pathology services provided in home and community based settings. PT OT SP and other therapies provided in a setting outside the home are limited to 20 visits of each therapy type per calendar year.

Respiratory Therapy

A licensed and registered Respiratory Therapist will perform preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.

Medical Social Services

Social workers will provide information, make referrals, and assist with obtaining or maintaining benefits which include financial assistance, medical assistance, food stamps, or other support programs provided by the LDSS, Social Security Administration, and other sources. Social services also involve providing supports and addressing problems in your living environment and daily activities to assist you in remaining in the community. These services will be provided by a qualified social worker as defined in NYS regulations.

Private Duty Nursing

Medically necessary services provided at your permanent or temporary place of residence, by a licensed registered professional or licensed practical nurses (RNs or LPNs) in accordance with physician orders. These services may be continuous and may go beyond the scope of care available from certified Home Health Agencies (CHHAs). Should you require continuous and skilled nursing care provided in your home, we will arrange for properly licensed registered professional or licensed practical nurses to provide that care.

Home Health Aide

A person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to an Enrollee with health care needs in his home.

Personal Care Aide

A person who provides some/total assistance with such activities as personal hygiene,

dressing, feeding and nutritional and environmental support functions. Personal care must be medically necessary, ordered by the Enrollee's physician and provided by a person qualified under NYS regulations in accordance with a PCSP.

Consumer Directed Personal Assistance Program (CDPAP)

The purpose of the Consumer Directed Personal Assistance Program is to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services. Assistance is provided for some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a member or the member's designated representative.

A Personal Assistant is an adult who provides consumer directed personal assistance to a member under the member's instruction, supervision and direction or under the instruction, supervision and direction of the member's designated representative. A member's spouse, parent or designated representative may not be the consumer directed personal assistant for that member; however, a consumer directed personal assistant may include any other adult relative of the member who does not reside with the member or any other adult relative who resides with the member because the amount of care the member requires makes such relative's presence necessary.

The plan must assess whether the individual is eligible for the program. The assessment process includes a physician's or practitioner order, a social assessment and a nursing assessment to determine if this is the appropriate level of assistance.

Dental Care

We believe that providing you with good dental care is important to your overall health. We offer dental care through Denta Quest as indicated in the provider network section. Covered **Dentistry** services includes but shall not be limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.

How to Access Dental Services:

Dental services are administered through Denta Quest who has a large network of dental providers that can meet your personal needs.

To find a dentist in your area, call 1-844-824-2024 or TTY/TDD 1-800-466-7566 and tell them you are a member of Nascentia Health Options. The operator will give you a list of dentists near you that you can choose from.

For further assistance in arranging dental services you can contact your Care Manager and they will help you schedule an appointment.

Make sure you bring your Member ID card with you to your appointment so the dentist can

bill us.

Vision Care

Maintaining healthy eyes and vision is an important aspect of our member's health. Routine eye exams are covered every 2 years unless medically needed more often. **Optometry** includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses; medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the Enrollee's condition. Examinations which include refraction are limited to every two years unless otherwise justified as medically necessary. Glasses, frames and lenses are provided every 2 years or more often if medically needed. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts will duplicate the original prescription and frames. Repairs to and replacement of frames and/or lenses must be provided as needed. We offer vision care through contracts with those listed in our provider network section.

How to Access Vision Care Services:

Contact your Care Manager for authorization and make an appointment with one of our Network Providers. Should you need assistance in arranging for vision care, your Care Manager can assist you in making an appointment. When you visit the optometrist, show your Member ID card to access your vision benefit.

Social & Environmental Supports

Services and items that support the medical needs of the members and are included in a member's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chores services, housing improvement, and respite care. Your Care Manager will help arrange these services if you require them.

Residential Health Care Facility Care (Nursing Home)

Our goal is to maintain you in your own home in the community. At times, when ordered by your physician and authorized by Nascentia Health Options, nursing home care may be required for a short time after a hospital stay. Your Care Manager will work with the licensed facility to develop a plan for rehabilitation and a quick return to your home.

Non-Emergency Transportation

Nascentia Health Options covers non-emergency medical transportation. Transportation by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Enrollee's condition for the Enrollee to obtain necessary medical care and services. You can contact Member

Services to arrange for transportation at 888-477-HOME (4663) If you require an attendant or special transportation arrangement, please make member services aware of your special need. If you have questions about transportation, please call Member Services at 888-477-HOME (4663).

Transportation requests must be made 72 hour in advance. Requests for same day transport will be accommodated when possible but there is no guarantee that the transportation vendor will be able to accommodate the request on such short notice.

Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics

If you require medical equipment or devices, your PCP in collaboration with your Care Manager and other members of the interdisciplinary team will make arrangements for you to obtain these items. DME includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula* and hearing aid batteries. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics:

- Can withstand repeated use for a protracted period of time,
- Are primarily and customarily used for medical purposes,
- Are generally not useful in the absence of an illness or injury; and
- Are not usually fitted, designed or fashioned for a particular individual's use.
- Where equipment is intended for use by only one patient, it may be either custom-made or customized.

Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value. If you have questions or believe you may need certain equipment contact your Care Manager at 888-477-HOME (4663)

*Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism

Prosthetics are appliances and devices, which replace any missing part of the body.

Orthotics are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. * Prescription footwear and inserts are limited to use in conjunction with a lower

limb orthotic brace, as part of a diabetic treatment plan.

Podiatry

For those Members that require podiatry services for routine foot care when your physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections will be authorized by your Care Manager. We offer podiatry care through contracts with those listed in our provider network section. Members with diabetes may require more frequent foot care. Your Care Manager will assist in the authorization and coordination of that care. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.

Audiology/ Hearing Aids

Nascentia Health Options will arrange for hearing evaluations for those Members that are having hearing difficulties. Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting, and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts. If you require a hearing aid your Care Manager will assist in the authorization of the hearing aid.

Adult Day Health and Social Day Care Programs

Your Care Manager in conjunction with your PCP and interdisciplinary team may determine that attendance at one of these day programs is a compliment to your other home and community based services. Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental pharmaceutical, and other ancillary services.

Social Day Care

A structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance. Your Care Manager will authorize the program and frequency of attendance based on your medical and functional status.

Emergency Response System

You may be at risk for falls or require rapid response from an emergency. The Emergency Response System is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a patient's phone and signal a response center once a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center. Your Care Manager will discuss with you if this service is right for you.

Nutrition & Meals

A qualified nutritionist can provide an assessment of nutritional needs and food patterns, the planning for the provision of foods and drink appropriate for your physical and medical needs, or the provision of nutrition education and counseling. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake, nutritional education regarding therapeutic diets, and development of a nutritional treatment plan. Home-delivered or congregate meals may be authorized by Nascentia Health Options Care Manager when this service is required to meet your medical, functional and nutritional needs.

Telehealth Services

Telehealth delivered services use electronic information and communication for telehealth providers to deliver health care services, which include the clinical discipline assessment, diagnoses consultation, treatment, education, care management and/or self-management of an Enrollee. The contractor is responsible for covering services in the benefit package that are delivered by telehealth in accordance with Section 2999-cc of the Public Health Law.

Hospice Services

Hospice services provide appropriate skilled, compassionate care to patients and their families so that they receive the support, help and guidance they need to meet the challenges of serious illness. It focuses on comfort, emphasizes quality of life, and promotes personal choice and individual dignity. Hospice services are available to enrollees who meet hospice eligibility requirements and are not enrolled in Hospice services prior to their enrollment into our plan.

Veterans Home Services

If you are a veteran, spouse of a veteran or Gold Star parent member in need of long term placement, and desire to receive care from a veteran's home, we will assist you in accessing and receiving veteran's home services.

Limitations

Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:

1. tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; **and**
2. individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

Nursing Home Care is covered for individuals who are considered a permanent placement for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from Nascentia Health Options.

Getting Care outside the Service Area

You must inform your care manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your care manager should be contacted to assist you in arranging services.

Emergency Service

Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify Nascentia Health Options within 24 hours of the emergency. You may be in need of long term care services that can only be provided through Nascentia Health Options.

If you are hospitalized, a family member or other caregiver should contact Nascentia Health Options within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact Nascentia Health Options so that we may work with them to plan your care upon discharge from the hospital.

TRANSITIONAL CARE PROCEDURES

New members in Nascentia Health Options may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to Nascentia Health Options quality assurance and other policies, and provides medical information about the care to your plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

MONEY FOLLOWS THE PERSON (MFP)/OPEN DOORS

This section will explain the services and supports that are available through **Money Follows the Person (MFP)/Open Doors**. MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP/Open Doors if you:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in their community

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Giving you information about services and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you need at home

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that Nascentia Health Options does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 888-477-HOME (4663) if you have a question about whether a benefit is covered by Nascentia Health or Medicaid. Some of these services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription and non-prescription drugs, as well as compounded prescriptions are covered by regular Medicaid or Medicare Part D if you have Medicare.

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment

- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Intellectual and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services including:

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Family Planning

Certain medically necessary ovulation enhancing drugs when criteria are met.

SERVICES NOT COVERED BY NASCENTIA HEALTH OPTIONS OR MEDICAID

You must pay for services that are not covered by Nascentia Health Options or by Medicaid if your provider tells you in advance these services are not covered, AND you agree to pay for them. Examples of services not covered by Nascentia Health Options or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless Nascentia Health Options sends you to that provider)

If you have any questions, call Member Services at 888-477-HOME (4663).

SERVICE AUTHORIZATIONS, ACTIONS AND ACTION APPEALS

When you ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request:

You or your primary care provider may contact Member Services at 888-477-HOME (4663) for authorization for these services.

We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period**.

Prior Authorization

Some covered services require prior authorization (approval in advance) from Nascentia Health Options before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must

be approved before you get them:

- Home Care, including Nursing, Home Health Aide, Occupational, Physical and Speech Therapies
- Audiology/Hearing Aids
- Dental Care (except for routine preventative care every 6 months)
- Vision Care (except for routine eye exam and glasses every 2 years)
- Respiratory Therapy
- Nutrition
- Medical Social Services
- Personal Care (such as assistance with bathing, eating, dressing, etc.)
- Podiatry (foot care)
- Non-emergency transportation to receive medically necessary services
- Home Delivered and/or meals in a group setting (such as a day center)
- Medical Equipment
- Social Day Care
- Prostheses and Orthotics
- Social/Environmental Supports (such as chore services or home modifications)
- Personal Emergency Response System
- Adult Day Health Care
- Nursing Home Care

Concurrent Review

You can also ask Nascentia Health Options to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review

Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request?

The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast track** process. You or your doctor can ask for a **fast track** review if it is believed that a delay will cause serious harm to your health. If your request for a **fast track** review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Timeframes for prior authorization requests

- **Standard review:** We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- **Standard review:** We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- **Fast track review:** We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a **fast track** review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 888-477-HOME (4663) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

If our answer is YES to part or all of what you asked for, we will authorize the service

or give you the item that you asked for.

If our answer is NO to part or all of what you asked for, we will send you a written notice that explains why we said no. See ***How do I File an Appeal of an Action?*** which explains how to make an appeal if you do not agree with our decision.

What is an Action?

When Nascentia Health Options denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions. An action is subject to appeal. (See *How do I File an Appeal of an Action?* below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; **and**
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you must file an appeal before asking for a Fair Hearing; **and**
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 day of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 888-477-HOME (4663) or writing to Nascentia Health Options, 1050 West Genesee Street, Syracuse, New York 13204. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for 6, see "***How do I File an Appeal of an Action?***" above.

Although you may request a continuation of services, if the plan appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will It Take the Plan to Decide My Appeal of an Action?

Unless your appeal is fast tracked, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending,

we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request a “*fast track*” appeal. (See “**Fast Track Appeal Process**” section below.)

Fast Track Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a *fast tracked* review of your appeal. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for a *fast track* appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for a *fast track* appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under “**How Long Will It Take the Plan to Decide My Appeal of an Action?**” above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.

If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

Your benefits will continue until you withdraw the Fair Hearing or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you

receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance (OTDA):

- Online Request Form: [Request Hearing | Fair Hearings | OTDA \(ny.gov\)](#)
- Mail a Printable Request Form:
NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023
- Fax a Printable Request Form: (518) 473-6735
- Request by Telephone:
Standard Fair Hearing line – 1 (800) 342-3334
Emergency Fair Hearing line – 1 (800) 205-0110
TTY line – 711 (request that the operator call 1 (877) 502-6155)
- Request in Person:
New York City
14 Boerum Place, 1st
Floor Brooklyn, New York
11201

Albany
40 North Pearl Street, 15th Floor
Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:
<http://otda.ny.gov/hearings/request/>

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information

about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast track external appeal. The external appeal reviewer will decide a fast track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

COMPLAINTS AND COMPLAINT APPEALS

Nascentia Health Options will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Nascentia Health Options staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint, please call: 888-477-HOME (4663) or write to:

Nascentia Health Options, 1050 West Genesee Street, Syracuse, New York
13204.

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you, didn't show up, or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial compliant decision.

For standard complaint appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the *fast track* complaint appeal process. For *fast track* complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and *fast track* complaint appeals, we will provide you with written notice of our decision of your complaint appeal. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like Nascentia Health Options. This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

- Phone: 1-844-614-8800 (TTY Relay Service: 711)

- Web: www.icannys.org | Email: ican@cssny.org

DISENROLLMENT FROM NASCENTIA HEALTH OPTIONS MLTC PLAN

You will not be disenrolled from the MLTC Plan based on any of the following reasons:

- high utilization of covered medical services
- an existing condition or a change in your health
- diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs unless the behavior results in your becoming ineligible for MLTC.

Voluntary Disenrollment

You can ask to leave the Nascentia Health Options at any time for any reason.

To request disenrollment, call 888-477-HOME (4663) or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTSS.

Transfers

You can try our plan for 90 days. You may leave Nascentia Health Options and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in (Insert Plan name) for nine more months, unless you have good reason (good cause.)

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving Nascentia Health Options is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause

To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. Nascentia Health Options will provide the care you need

until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in Nascentia Health Options.

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by Nascentia Health Options. If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of involuntary disenrollment reasons.

You Will Have to Leave Nascentia Health Options if you are:

- No longer are Medicaid eligible.
- Permanently move out of Nascentia Health Options service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- Hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- Assessed as no longer having a functional or clinical need for (CBLTSS) on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.
- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated.
- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We Can Ask You to Leave Nascentia Health Options if you:

- or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the plan's ability to furnish services
- fail to pay or make arrangements to pay the amount money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, Nascentia Health Options will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which you become ineligible for enrollment. If you continue to need CBLTSS you will be required to

choose another plan or you will be automatically assigned (auto-assigned) to another plan.

Spenddown

Some enrollees will be eligible for Medicaid by paying a spenddown. Your spenddown amount is determined by the Local Department of Social Services. If you have a spenddown (surplus) to be Medicaid eligible, you must pay this to Nascentia Health Options. Failure to pay your spenddown may result in loss of Medicaid eligibility and involuntary disenrollment from Nascentia Health Options.

Please send Spenddown payments to: Nascentia Health Options
1050 W Genesee St. Ste 2
Syracuse, NY 13204-9900

Nascentia Health Options may initiate Involuntary Disenrollment if a member fails to pay any amount owed as a Medicaid spenddown/surplus within 30 day after such amount becomes due. We will make reasonable efforts to collect the surplus, including written demand for payment and advising the member of his/her prospective disenrollment.

CULTURAL AND LINGUISTIC COMPETENCY

Nascentia Health Options honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

MEMBER RIGHTS AND RESPONSIBILITIES

Nascentia Health Options will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

Member Rights

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.

- You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- You have the Right to get information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services.
- You have the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

- Receiving covered services through Nascentia Health Options.
- Using Nascentia Health Options network providers for covered services to the extent network providers are available.
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs.

- Sharing complete and accurate health information with your health care providers.
- Informing Nascentia Health Options staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- Following the plan of care recommended by the Nascentia Health Options staff (with your input).
- Cooperating with and being respectful with the Nascentia Health Options staff and not discriminating against Nascentia Health Options staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status.
- Notifying Nascentia Health Options within two business days of receiving non-covered or non-pre-approved services.
- Notifying your Nascentia Health Options health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing Nascentia Health Options before permanently moving out of the service area, or of any lengthy absence from the service area.
- Your actions if you refuse treatment or do not follow the instructions of your caregiver.
- Meeting your financial obligations.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your care manager.

Information Available on Request

- Information regarding the structure and operation of Nascentia Health Options.
- Specific clinical review criteria relating to a particular health condition and other information that Nascentia Health Options considers when authorizing services.

- Policies and procedures on protected health information.
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.
- Provider credentialing policies.
- Provider Directory: Nascentia Health Options has a contract with the New York State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These home care agencies, day care programs, meals on wheels providers, dentists and health care facilities are a few of the services included in our provider network. You'll find a list in our provider directory. If you don't have a provider directory, call Nascentia Health Options to get a copy.
- A recent copy of the Nascentia Health Options certified financial statement; policies and procedures used by Nascentia Health Options to determine eligibility of a provider.

Nondiscrimination Notice

Nascentia Health complies with Federal civil rights laws. Nascentia Health care does not exclude people or treat them differently because of race, color, national origin, disability, age or sex.

Nascentia Health provides the following:

- Aids and services to people with disabilities to help communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose first language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Nascentia Health at 1-888-477-HOME (4663); TTY 711

If you believe that Nascentia Health has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Nascentia Health by:

- Phone: 1-888-HOME (4663) TTY users should call: 711
- Fax: 1-315-870-7788
- Mail:

Nascentia Health
Attn: Corporate Compliance 1050 West Genesee
Street Syracuse, NY 13204

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- Web Office for Civil rights Complaint
Portal at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Mail U.S. Department of Health and Human Services
200 Independence Avenue SW., Room
509F, HHH Building Washington, DC
20201

Complaint forms available at
<http://www.hhs.gov/ocr/office/file/index.html>
- Phone 1-800-868-1019 (TTY/TDD 800-537-7697)

Language Assistance

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-888-477-4663 TTY/TDD 711.	English
ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-477-4663 TTY/TDD 711.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-477-4663 TTY/TDD 711.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فمن خدمات المساعدة اللغوية متوافر لك بالمجان. اتصل برقم 1-888-477-4663 (رقم هاتف الصم والبكم). رقم 711 (.	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-888-477-4663 TTY/TDD 711 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, товам доступны бесплатные услуги перевода. Звоните 1-888-477-4663 (телефон: 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-477-4663 TTY/TDD 711.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-477-4663 TTY/TDD 711.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-477-4663 TTY/TDD 711.	French Creole
איפטערקזאָם: אויב אַיר רעדט אַידיש, זענען פֿאַרְהָאָן פֿאַר אַיר שפֿראָך הַילְך סֻעָרְוִיסּוּסּוּ פֿרִי פֿון TTY: 711 1-888-477-4663 אַפְצָאָל. רֹופְט->4663	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-477-4663 TTY/TDD 711	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-477-4663 TTY/TDD 711.	Tagalog
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